DWS-UI
FORM 615-CW
REV.07/99

WK COMP

UTAH DEPARTMENT OF WORKFORCE SERVICES
UNEMPLOYMENT INSURANCE STATEMENT
PO Box 45266, Salt Lake City, UT 84145-0266
FAX: (801) 526-4402

REGARDING CLAIMS FOR BENEFITS

Claimant's Name_____ Social Security No. _____

Date of work-related injury or illness: MO_____ DAY_____ YEAR_____

What was your injury or illness? _____

City/State where you were working when you were injured: _____

Were you paid Worker's Compensation for lost wages? Yes [ ] No [ ]

If YES, please complete the following:

What state paid benefits? _____

Name of insurance company: _____ File _____

Adjustor's name: _____ Phone #_____

Dates paid Worker's Compensation: from _____ to _____

Type of compensation (circle one): Temporary Total / Permanent Partial / Other

Date released by doctor to return to full-time work: _____

(If your release date is more than 90 days ago, explain why you did not file until now): _____

_____

_____

Do you have physical restrictions which affect your ability to work full-time?

YES [ ] NO [ ] (If YES, please explain): _____

Have you contacted your former employer since your release? YES [ ] NO [ ]

Why aren't you working there now?_____

I CERTIFY the information on these pages is true, correct, and complete. I have made these statements to obtain unemployment benefits, knowing that the law provides penalties for false statements or withholding material facts.

Date _____ Signature_____

DO NOT WRITE BELOW THIS LINE

[ ] Allowed [ ] Denied Sec. _____ Eff. _____

Reasoning statement: _____

_____

_____

_____

_____

_____

Dept. Repr._____ Employee # _____ Date _____